FAMILY FIRST CHIROPRACTIC PC

PATIENT CASE HISTORY CHILDREN BIRTH – 15 YEARS OLD

Dear Parent:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your child's case.

Patient (Child) Information:

Child's Name: _____ Patient SSN: _____

Gender: _____ Age: _____ Date of Birth: _____

Mailing Address: _____City: _____ State: ____ Zip: _____

How did you learn about our office (be specific)? _____

Parent's/Guardian's Information:

Mother's Name: _____ Contact Phone: _____

Father's Name: _____ Contact Phone: _____

Email Address: _____

Which parent do we contact regarding your child's care? ☐Mother ☐Father ☐Either

Prenatal/Birth History:

Delivery/Birth Intervention: ☐Vaginal ☐Forceps ☐Vacuum Extraction ☐C-Section ☐Breech

Place of Birth: ☐Home ☐Birthing Center ☐Hospital

Any complications during pregnancy? ☐Yes ☐No If yes, please explain: _____

_____

Any complications during labor/delivery? ☐Yes ☐No If yes, please explain: _____

_____

Was there presence at birth of: ☐ Jaundice (yellow) ☐ Cyanosis (blue)

Were there any Congenital Anomalies/Defects: ☐Yes ☐No If yes, please explain: _____

_____

Were there any Genetic Disorders or Disabilities: ☐Yes ☐No If yes, please explain: _____

_____

Did mother smoke during pregnancy? Y / N Cigarettes or alcohol during pregnancy? Y / N

Was mother ill during pregnancy? Y / N Did mother exercise during pregnancy? Y / N

Medications taken during pregnancy/delivery (list): _____

Child's birth weight: _____ Child's birth height/length: _____

Health Information:

Is your child here for: ☐ Wellness Checkup ☐ Specific Complaint

If a specific complaint, please explain: _____

_____

When did this condition begin? _____

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Child's Name: _____

Has your child had this condition in the past? ☐Yes ☐No

Has your child had any prior treatment for this complaint (if yes, describe)?_____

_____

Was there an accident or injury involved? _____

Which activities aggravate your child's condition? _____

General Questions:

How many times has your child been prescribed antibiotics in the past 6 months? _____

Total times during lifetime? _____

Is their condition getting progressively: ☐ Worse ☐ Better ☐ Staying the Same

Is their condition interfering with their: ☐ School ☐ Sleep ☐ Daily Routine

☐ Other, please explain: _____

Obstetrician/Midwife's Name: _____ Date of last visit: _____

Pediatrician's Name: _____ Date of last visit: _____

Medications your child currently takes:

☐OTC pain/fever reducer (type/dosing/frequency): _____

☐Allergy Medicine (type/dosing/frequency): _____

☐Vitamins (type/dosing/frequency): _____

☐Medications (type/dosing/frequency): _____

Has your child ever suffered from: ☐Colic ☐Ear Infection ☐Asthma ☐Recurrent Cold

☐Chronic Cough ☐Other: _____

Do you feel that your child is sick often? ☐Yes ☐No

If yes, explain: _____

Any childhood falls headfirst from a high place during their first year of life (ie.: a bed, changing table, down the stairs, etc)? Y / N If yes, explain: _____

Is/has your child been involved in any high-impact or contact type of sports (i.e.: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.? Y / N List: _____

Has your child been in an auto accident, even a minor "fender bender"? ☐Yes ☐No

If yes, when? _____

Has your child had any other injuries/accidents/traumas not listed ? ☐Yes ☐No

If yes, list: _____

List all surgeries (include year performed):

_____

_____

Immunization History:

☐DPT ☐MMR ☐Chicken Pox ☐Polio ☐Flu Shot ☐Hep B ☐ Pertussis/Whooping Cough

☐Other: _____ Any adverse reactions? _____

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Child's Name: _____

Childhood Diseases:

Chicken Pox: Y / N Age: _____ Rubella: Y / N Age: _____ Mumps: Y / N Age: _____

Measles: Y / N Age: _____ Whooping Cough: Y / N Age: _____ Other: _____ Age: _____

Feeding History:

Breast Fed: Y / N How long? _____ Formula Fed: Y / N How long? _____

Introduced Solids at _____ months. Introduced cow's milk at _____ months.

Food Allergies or Intolerances: Y / N If yes, list: _____

Did your child ever suffer from colic, reflux, or constipation? Y / N If yes, list: _____

Developmental History:

During the followng times, your child's spine is the most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). **At what age was your child able to do the following?**

Respond to Sound: _____ Cross Crawl: _____

Respond to Visual Stimuli: _____ Stand Alone: _____

Hold Head Up Alone: _____ Walk Alone: _____ Sit Up Alone: _____

Does your child have any consistent postural behavior (ie. Always rests head on left side or right side, specific seated posture, leaning on one leg more than the other, etc): _____

_____

Review of Systems:

Please check if your child has had any of the following:

_____ Headaches	_____ Postural Imbalances	_____ Growing Pains
_____ Scoliosis	_____ Tonsillitis	_____ Asthma
_____ Torticollis	_____ Ear Infections	_____ Seizures
_____ Sleep Problems	_____ Digestive Problems	_____ Bedwetting
_____ PDD/Autism	_____ ADD/ADHD	_____ Frequent Fever
_____ Colic	_____ Learning Difficulties	_____ Acid Reflux
_____ Hip Dysplasia	_____ Allergies	

Any behavioral, social, or emotional issues? _____

_____

How many hours a day does your child typically spend watching TV, computer, tablet, or phone? _____

How would you rate your child's diet? ☐ Well-Balanced ☐ Average ☐ High sugar/processed foods

Does your child consume artificial sweeteners? Y / N

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Child's Name: _____

Number of hours your child sleeps: _____ hours per night ____ hours per day/naps
Sleep quality: ☐ Good ☐ Fair ☐ Poor
What is your primary goal for your child at our clinic? _____

Family History	Diseases in the Family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

I understand that it is my responsibility to complete these clinic forms accurately. The above information is correct to the best of my knowledge. It is my responsibility to notify the doctor if any of this information has changed or requires an update.

_____ _____ _____

Parent/Legal Guardian's Name (PRINTED) Parent/Legal Guardian's Signature Date

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APPOINTMENT POLICY

In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. **Be on time for your appointments.** We strive to see all our patients at their scheduled time, running late for your appointment will either push back our subsequent patients or cause you to have to wait until the doctor is able to see you. Please remember that we have reserved appointment times especially for you. Therefore, **we request at least 24 hour notice in order to reschedule your appointment**. This will allow us to offer that cancelled time to another patient. When you cancel your appointment at the last minute, everyone loses- you, the doctor and other patients that would have utilized your appointment time. Please realize how important it is to keep your reserved time.

_____ _____ _____

Patient's Name (PRINTED) Parent/Legal Guardian's Signature Date

Appointment Reminders:

We have the option to send an email and/or text reminder for your child's appointments. Please select **ONE** or **BOTH** and provide the information below:

Text alerts, initial here: _____ Cell Phone Number with area code: _____

Email alerts, initial here: _____ Email Address (print clearly): _____

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FINANCIAL POLICY

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

All payments are due at the time of service unless prior arrangements have been made. Any balance left over 30 days may be subject to a 5% interest charge. **CHECKS ARE NOT ACCEPTED.**
We **DO NOT** process any other insurance in our office. We are an **OUT-OF-NETWORK PROVIDER** according to your plan description. We can print you an itemized Superbill for **YOU** to submit for **POSSIBLE** reimbursement.

Product Purchases

All products must be paid for at the time they are received (in stock items) or ordered (custom products, such as orthotics).

The above mentioned policies were designed to make things easier for all of us. Thank you for your cooperation. By signing below, the patient agrees to abide by the policies listed above.

_____	_____	_____
Patient's Name (PRINTED)	Parent/Legal Guardian's Signature	Date

No Surprises Act and Good Faith Estimates

Under the law, healthcare providers need to give patients who don't have insurance or who are not using insurance, an estimate of the bill for medical items and services.
This Good Faith Estimate shows the costs of services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created. Please be advised your costs may change depending on the number of adjustments you actually come in for. Extra adjustments may be recommended based upon your healing progress; this will be charged the standard adjustment rate.
You can ask your healthcare, and any other provider you choose, for a Good Faith Estimate before you schedule a service.
If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775.

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including, but not limited, to examination tests, diagnostic x-Ray(s) and physical therapy techniques (including Rock Tape application), on me (or on the patient named below, for whom I am legally responsible) which are recommended by Dr. Ryan Gutierrez and/or other licensed Doctor of Chiropractic who will now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Family First Chiropractic.

The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms. While rare, in the practice of chiropractic there are some risks to treatment including, but not limited to: sprains/strains, increased symptoms or pain, no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the body's nerve system. Our only method is specific adjusting to correct subluxations (misalignments).

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read and fully understand the above statement. I have also had an opportunity to ask questions and all of my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek care.

CONSENT TO EVALUATE AND TREAT A MINOR (TREATMENT OF A CHILD UNDER 18 YRS)

I, _____, the undersigning parent/guardian having legal custody/guardianship of _____, a minor, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive an examination, chiropractic diagnosis or treatment which is deemed necessary. I understand and agree that all services rendered to my child are charged directly to me and that I remain personally responsible for payment.

_____ _____

Parent/Legal Guardian's Signature Date

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HIPAA CONSENT AND ACKNOWLEDGEMENT

I acknowledge that Family First Chiropractic's HIPAA (Notice of Privacy Practices) has been provided to me.

The Notice of Privacy Practices describes the uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Family First Chiropractic. The Notice of Privacy Practices also describes my rights and Family First Chiropractic's duties with respect to my protected health information.

Family First Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA.

If patient is a minor or under a guardianship order as defined by State Law:

_____	_____	_____
Patient's Name (PRINTED)	Parent/Legal Guardian's Signature	Date